Joint Senate Public Health and Senate Human Services Committee
Subject Matter Hearing: Nursing Home Patient Safety
Testimony from
Office of the State Long Term Care Ombudsman Program
Sally Petrone, State Ombudsman
November 5, 2009

Chairs and members of the Senate Public Health and Senate Human Services Committee, thank you for the opportunity to address the safety in nursing homes. My name is Sally Petrone and I am the Illinois State Long Term Care Ombudsman.

As mandated by the Older Americans Act, the mission of the Long Term Care Ombudsman Program (LTCOP) is to seek resolution of problems and advocate for the rights of residents of LTC facilities with the goal of enhancing the quality of life and care of residents. The program acts solely on behalf of the thousands of individuals who live in long term care facilities. Ombudsmen monitor quality by investigating and resolving resident complaints, provide information, monitor regulations and government agency action impacting residents and represent resident interests to policy makers.

In Illinois, there are 16 Regional (Long Term Care Ombudsman) Programs with roughly 260 certified ombudsmen & of that number, 18% or 47 are full time paid ombudsmen. In FY08, Ombudsmen received and worked to resolve over 9,700 complaints and handled over 22,000 consultations. Despite efforts to improve quality in NHs, complaints increase year after year and have become more complex. No longer are our common complaints about cold coffee & peas. They are about lack of nursing staff, lack of safety, inappropriate placements, involuntary discharges, accidents and improper handling, lack of dignity and poor staff attitudes, & inadequate care plans.

Ombudsmen are the eyes and ears of residents and often times the only ones trusted by residents. Ombudsmen visit facilities more than any other advocacy program -in FY08, they made 20,706 facility visits. We've built strong relationships with the ISP Medicaid Fraud units, county coroners, the local law enforcement, ICASA, rape crisis centers, mental health professionals, states attorneys offices, private attorneys, & state agencies. And, we receive many referrals from your district offices – we're happy to help your constituents.

We are all working on making nursing homes safe and we need the General Assembly's cooperation since legislative changes will be needed. I understand that you are looking for solutions to improve the safety. Please consider the following solutions:

1. We should draw attention to the evaluating the entire process of the criminal history analysis reports completed by IDPH and its contractors, VIP Security and

Detective Services and private psychologists. My Office, housed at IDoA, receives a copy of every report. After reviewing, I forward to the designated regional program. Sine the law passed in 2006, (Public Act 94-752), I've seen very few history assessments checked as "high risk" and find it hard to believe that residents such as the two examples I'll speak of have been classified as "moderate risk". First example, a 25 year old male, with convictions for public indecency in 2008, aggravated battery with firearm in 2006, domestic battery in 2005, retail theft in 2004, has a major mental illness was deemed at "moderate risk". Second example is the 69 year old male with convictions for burglary and a murder. Assessment indicates he has several medical disorders. Although the murder occurred in 1981, he was most recently in prison from 2006-2007. Assessment gives no reason for the 2006 prison sentence. Specifically, I'm concerned that the scale has been lowered over time which ultimately elevates the imminent risk of being victimized.

2. Do not allow sex offenders to be admitted to NHs. And, for those sex offenders living in NHs, they need to be removed. No sex offender deserves a private room and have it be paid by Medicaid.

3. Tighten the pre-admission screening process to make it more comprehensive. This is when the criminal background checks should be done- not after admittance. The screening should include a review of the past resident's medical records, drug history, mental health treatment, care plans, & criminal history.

4. Develop an assessment tool to determine the level of danger a resident is to themselves and to others before being admitted to a NH. Not all seriously mentally ill persons are dangerous to others. With the rise of suicides occurring in NHs by the older population and with the rise of resident to resident incidents reports filed at IDPH by NHs, NHs need intensive training on intervention and prevention.

5. Stop housing the SMIs and substance abusers with the frail elderly in NHs. The typical NH can't handle either population. NHs don't have the qualified and trained MH staff nor do they meet their needs.

5. HFS should expand the Illinois Medicaid waiver or develop a new waiver to cover community care for those with a primary diagnosis with mental illness.

6. Raise the Personal Needs allowance. We hope that you will work with us on passing legislation in the future. $30.00 a month does not cut it to buy personal care items, birthday cards for their families, disposable undergarments, and the daily newspaper.

7. Find a way to increase funding for the Ombudsman Program. With no funding increase since FY2000 combined with substantial cuts in Civil Monetary Penalty Fines (CMP) and state funds, the 16 regional programs are forced to layoff off

staff and cut Ombudsman services. Ombudsmen will be drastically reducing the number of facility visits in FY2010 which will ultimately weaken Ombudsmen visibility, alter the residents' sense of safety and well being, and cut off the voice of those who strongly advocate for them.

We ask you to consider a few innovative ideas to increase funding for the program:
1) carve out a paid role for Ombudsmen in the Money Follows the Person Program. We already are in the facilities – why not pay us to educate, market, publicize and find eligible residents who want to be transitioned into the community?
2) Look at the State of Ohio's statutes requiring licensed facilities to pay a bed fee - not a bed tax that is deposited in the State Treasury and credited to the LTCOP;
3) implement a LTC Consumer Guide similar to the State of Ohio. Facilities are required to participate and are charged $400/year which is paid to the Ombudsman Program to maintain the state of the art guide which includes satisfaction surveys, policies, bed rates, quality measures, and past PH surveys. A less sophisticated guide was implemented in 2008 when the Illinois Residents Right to Know Act was passed. By law, Illinois facilities are required to complete a Consumer Choice Information Report which are available on line and maintained by the Ombudsman Program - and at no charge. We need to improve and expand the consumer reports so every detail about facilities is in one location. Consumers want to be informed and knowledgeable & don't want to look at 5 or 6 web sites; and,
4) Fund HB1301 which passed in FY2007 – this bill authorized the LTCOP to advocate and serve ALL residents in LTC facilities regardless of age. Until adequate funding becomes available and we have the manpower to serve those under 60 years of age, the under 60 population will fall through the cracks and not be served.

I'd like to encourage each and every one of you to visit a nursing facility in your district. Call me and I can arrange an Ombudsman to visit with you. You should get to know your constituents and now is the time for them to know you.

I also want to acknowledge the commitment of the Governor's Task Force on NH Safety. I hope that we can work together and apply evidence based practices and approaches to make nursing homes a safe place to live.

Thank you for the opportunity to testify and to draw attention to the important topic of safety in nursing homes.

Sally Petrone
Illinois State Long Term Care Ombudsman

Supportive Housing Providers Association

Membership List

	Organization	Location	Population Served
1.	AIDSCare, Inc.	Chicago	Individuals and families with HIV/AIDS
2.	AIDS Foundation of Chicago	Chicago	Individuals and families with HIV/AIDS
3.	Alexian Brothers Bonaventure House	Chicago	Individuals with HIV/AIDS
4.	Alliance to End Homelessness in Suburban Cook County	Suburban Cook County	Continuum of Care
5.	Ambassadors for Christ CDC	Chicago	Homeless families
6.	Association for Individual Development	Aurora	Individuals with mental illness
7.	Bethel Human Resources	Harvey	Homeless individuals
8.	Bethel New Life	Chicago	Homeless & low income families & individuals
9.	Brand New Beginnings	Chicago	Homeless families
10.	Bridgeway	Galesburg	Individuals with mental illness
11.	Butler Woodcrafters		For-profit furniture maker
12.	Call for Help	East St. Louis	Homeless individuals & families
13.	The Carpenter's Place	Rockford	Homeless families & individuals
14.	Cathedral Shelter	Chicago	Homeless individuals & families
15.	Catholic Charities	Chicago	Homeless individuals
16.	CDBG Operations	East St. Louis	Homeless families
17.	Chestnut Health Systems	Granite City	Individuals with mental illness
18.	Chicago Christian Industrial League	Chicago	Homeless individuals
19.	Chicago House and Social Service	Chicago	Individuals with HIV/AIDS

	Organization	Location	Population Served
	Agency		
20.	Christian Community Health Center	Chicago	Homeless families and individuals
21.	Community Counseling Center of N. Madison County	Alton	Individuals with mental illness
22.	Community Counseling Centers of Chicago	Chicago	Individuals with mental illness
23.	Connections for the Homeless	Evanston	Homeless families and individuals
24.	Cornerstone Services	Joliet	Individuals and heads of households with mental illness
25.	Corporation for Supportive Housing	Chicago	Provide technical assistance, pre-development funding, and federal advocacy
26.	Crosspoint Human Services	Danville	Homeless individuals and families
27.	Deborah's Place	Chicago	Homeless single women
28.	Decatur Macon County Continuum of Care	Decatur	Continuum of Care
29.	DeKalb Continuum of Care	DeKalb	Continuum of Care
30.	Delta Center	Cairo	Individuals with mental illness
31.	DeWitt County Human Resource	Clinton	Individuals with mental illness
32.	DOVE/Homeward Bound	Decatur	Homeless families and individuals
33.	DuPage County Health Department	Wheaton	Individuals with mental illness
34.	DuPage P.A.D.S.	Wheaton	Homeless individuals
35.	Embarrass River Basin Agency	Greenup	Homeless individuals and families
36.	Featherfist	Chicago	Homeless individuals and families

	Organization	Location	Population Served
37.	Foothold Technologies	Chicago	For-profit software developer
38.	Franklin-Williamson Human Services	Marion	Individuals with mental illness
39.	Grand Prairie Services	Tinley Park	Individuals with mental illness
40.	Harley Ellis Devereaux	Chicago	For-profit architectural firm
41.	Heartland Alliance	Chicago	Homeless individuals and families
42.	Heritage Behavioral Health Center	Decatur	Individuals with mental illness
43.	Heart of Illinois Continuum of Care		
44.	Homestead Corporation	Champaign/Urbana	Homeless individuals
45.	Housing Authority of Henry County	Kewanee	Homeless individuals
46.	Housing Opportunities for Women	Chicago	Homeless women with and without children
47.	Housing Options for the Mentally Ill in Evanston	Evanston	Individuals with mental illness
48.	Human Service Center of Southern Metro-East	Red Bud	Individuals with mental illness
49.	Hoyleton Youth & Family Services	Hoyleton	Homeless individuals and families
50.	Human Resources Development Institute	Chicago	Individuals with Mental Illness
51.	Human Support Services	Waterloo	Individuals with mental illness
52.	Illinois Community Action Agency Association	Statewide	Statewide agency of community action agencies
53.	Illinois Veterans Home	Rantoul	Homeless individuals
54.	Inner Voice	Chicago	Homeless individuals
55.	Inspiration Corporation	Chicago	Homeless individuals
56.	Interdependent Living Solutions	Evergreen Park	Low-income, frail elderly
57.	Interfaith Council on the Homeless	Chicago	Homeless Families

	Organization	Location	Population Served
58.	La Casa Norte	Chicago	Homeless youth
59.	Lake County Continuum of Care		
60.	Lake County Residential Development Corp.	Gurnee	Homeless individuals
61.	Lazarus House	Chicago	Homeless individuals
62.	Life Links	Mattoon	Individuals with mental illness
63.	Lighten-Gale Group	Chicago	Development Consultants
64.	Madison County Community Development	Edwardsville	Homeless individuals
65.	Massac County Mental Health Center	Metropolis	Individuals with mental illness
66.	Mayor's Task Force on Homelessness (Continuum of Care)	Rockford	Homeless individuals and families
67.	M.E.R.C.Y. Communities	Springfield	Homeless families
68.	McHenry County Continuum of Care		
69.	Mercy Housing Lakefront	Chicago	Homeless individuals and families
70.	Mid Central Community Action	Bloomington	Homeless individuals
71.	National Alliance for the Mentally Ill—Illinois	Springfield	Statewide association for people with mental illness
72.	PADS Crisis Services	North Chicago	Homeless individuals
73.	Peoria Opportunities Foundation	Peoria	Homeless individuals
74.	Perry County Counseling Center	DuQuoin	Individuals with mental illness
75.	Pillars	Western Springs	Individuals with mental illness
76.	Project NOW, Inc.	Rock Falls	Homeless individuals
77.	Public Action to Deliver Shelter	Aurora	Homeless individuals

	Organization	Location	Population Served
78.	The Renaissance Collaborative	Chicago	Homeless individuals
79.	Renaissance Social Services	Chicago	Homeless individuals and families
80.	Residential Options	Alton	Homeless individuals
81.	A Safe Haven	Chicago	Homeless individuals
82.	A Safe Place	Lake County	Homeless individuals
83.	St. Clair County Continuum of Care	Belleville	Homeless individuals and families
84.	St. Leonard's Ministries	Chicago	Formerly incarcerated individuals
85.	The Sanctuary—S. Suburban Family Shelter	Matteson	Homeless families
86.	Shelter Care Ministries	Rockford	Homeless individuals
87.	Southeastern Illinois Community Counseling Centers	Olney	Individuals with mental illness
88.	S. Illinois Coalition for the Homeless	Marion	Homeless and low income families
89.	S. Illinois Continuum of Care		Continuum of Care
90.	S. Illinois Regional Social Services	Carbondale	Individuals with mental illness
91.	South Side Office of Concern	Peoria	Homeless individuals
92.	SWAN	Olney	Homeless individuals and families
93.	Tazwood Mental Health Center	Pekin	Individuals with mental illness
94.	This End Up Furniture	Chicago	For profit furniture company
95.	Thresholds	Chicago	Individuals with mental illness
96.	Together We Cope	Tinley Park	Homeless individuals
97.	Trilogy	Chicago	Individuals with mental illness
98.	Trinity Services	Lockport	Individuals with mental illness
99.	Urbana-Champaign Continuum of	Urbana-	Continuum of Care

	Organization	Location	Population Served
	Care	Champaign	
100.	West Central Continuum of Care		Continuum of Care
101.	West. Suburban PADS	Oak Park	Homeless individuals and families
102.	WilPower	Skokie	Individuals with mental illness
103.	Zion Development Corporation	Rockford	Homeless individuals

Illinois Senate Public Health and Human Services Committees
Joint Hearing on Nursing Home Safety

Testimony Presented by
Supportive Housing Providers Association
Janet Hasz, Executive Director
November 5, 2009

On behalf of the Supportive Housing Providers Association and our 118 member organizations across the state, I wish to thank the Senate Human Services and Public Health Committees and your Chairs, Sen. Mattie Hunter and Sen. William Delgado, for this opportunity to testify. I am here this morning to express our desire to be a partner in the solution to nursing home safety issues and to put forth supportive housing as a more cost effective and more progressive recovery model for people with mental illness than nursing homes. Also, supportive housing for people with mental illness leverages more than a 50% return in federal funding.

Defining Supportive Housing

Supportive housing is affordable, rental housing with services integral to the housing. It is designed for people who have been chronically homeless and/or for people with special needs, such as mental illness.

Supportive Housing for People with Severe Mental Illness

Today, I will be talking about supportive housing for people with mental illness. Currently, there are 3,911 units of supportive housing for people with severe mental illness in many locations throughout the state, each location having 16 or fewer units. These units include Community Integrated Living Arrangements (CILAs), supervised, and supported housing. Each of these supportive housing buildings is serviced and operated by a community mental health provider, who provides 12 to 24 hour on site services, around the clock on-call services, and access to all the services provided by the community health provider, including psychiatrists. There are also 265 permanent supportive housing bridge subsidy scattered site units. The state-licensed community mental health providers use tested evidence-based practices to move people living in supportive housing to recovery, and beyond— to reuniting with their families, with the community, and, in many instances, with employment. Individuals living in supportive housing pay 30% of their income for rent. They keep the rest of their income, affording them dignity and the ability to connect with the community around them.

Supportive housing –

- Enables even the most vulnerable to remain housed[1].
- Impacts positively on people with mental illness, affording both independence and much-needed support.
- Helps people with histories of substance abuse, stay clean and sober[2].

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[1] A study of almost 5,000 homeless individuals with mental illness placed in supportive housing confirmed that nearly 80 percent remained housing a year later, with 10 percent moving on to independent settings. Lipton, F.R. (1997). *The New York-New York Agreement to House Homeless Mentally Ill Individuals: Summary Placement Report.* New York, NY: New York City Human Resources Administration/Office of Health and Mental Health Services.

[2] A study in Minneapolis found that 90 percent of those living in supportive housing remained sober one year after completing a treatment program, while only 57 percent of those living independently stayed

- Helps people become employed[3].

Cost Effectiveness

The recently completed Study of Supportive Housing in Illinois[4] explored the kind and cost of public services used by 177 supportive housing residents two years before they entered supportive housing and two years after they moved into supportive housing. There were cost savings in every system studied from pre to post-supportive housing. There was a 39% reduction in the cost of services for an overall savings of $854,477. Most notably, the number of overnight stays in state mental health hospitals decreased almost 100% after individuals moved into supportive housing, for a savings of $400,000. There was a 100% decrease in the time spent in state prison and an 86% decrease in the time spent in county jails, for a savings of $240,000.

Cost Comparison

Nursing homes cost the State of Illinois an average of $117 per person per day. Supportive housing for the mentally ill costs the state an average of $28 per person per day. **The state could pay for four units of supportive housing with the same amount of money that it currently pays for one person in a nursing home.**

Leveraging Federal Dollars

Providers of supportive housing for people with mental illness provide Medicaid eligible services and the state receives a 50% Medicaid return for these services. On top of this 50%, supportive housing leverages federal funding for property acquisition, rehabilitation, new construction, and rental assistance, often through the U.S. Department of Housing and Urban Development's Section 811 program. On average this additional federal funding is four times the state's general revenue expenditure for supportive housing or **400% federal return on the state's investment on top of the 50% Medicaid reimbursement**.

Supportive Housing: A Partner in the Solution

Supportive housing is an effective, dignified solution for individuals with mental illness, moving these individuals to recovery and reintegration in the community. Supportive housing is very cost effective, costing less than nursing homes and leveraging a 450% federal return on the state's investment.

For all of these reasons, wise public policy dictates that supportive housing can and must be part of the solution for removing individuals under 65 with mental illness from nursing homes. To make this solution possible, the state must protect the current state service funding for existing supportive housing. It must also find funding, approximately $7 million, for services in the new supportive housing units coming on line, 537 units this year (FY 2010), 300 units in FY 2011, and 400 units in FY 2012.

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sober. Eden Programs, (1993). Unpublished manuscript. Minneapolis, MN: data available from Eden Programs and Corporation for Supportive Housing.

[3] Long, D.A., et al., (1999). *The "Next Step: Jobs" Initiative Cost-Effectiveness Analysis: Final Report.* New York, NY: Corporation for Supportive Housing.

[4] Supportive Housing in Illinois: A Wise Investment, April 2009, The Social Impact Research Institute of the Heartland Alliance.

SUPPORTIVE HOUSING IN ILLINOIS:
A WISE INVESTMENT

The full report of ***Supportive Housing in Illinois: A Wise Investment*** *is available at:*

www.heartlandalliance.org/research

www.supportivehousingproviders.org

www.csh.org

APRIL 2009

Supportive housing is permanent affordable housing coupled with supportive services that enables residents to achieve long-term housing stability. Residents include people who were homeless and those who have serious and persistent issues such as mental illness, chronic health problems, and substance use.

This analysis focused on 177 supportive housing residents in Illinois and the impact of supportive housing on their use of expensive, primarily publicly-funded services. Analysis compared the 2 years before they entered supportive housing with the 2 years after. Data were collected on these residents from Medicaid, mental health hospitals, substance use treatment, prisons, and various county jails and hospitals.

Key Findings

- There were cost savings in every system studied from pre- to post-supportive housing. There was a 39% reduction in the total cost of services from pre- to post-supportive housing with an overall savings of $854,477. This was an average savings of $4,828 per resident for the 2-year time period or $2,414 per resident, per year.
- Once in supportive housing, residents who had previously lived in more restrictive settings (i.e., nursing homes, mental health hospitals, and prisons) were unlikely to return.
- Residents shifted the type and volume of services they used—from a high reliance on expensive Inpatient/Acute services before supportive housing to less expensive Outpatient/Preventive services after supportive housing.
- Residents reported an increased quality of life after entry into supportive housing. Not only did their housing stabilize, but their health improved, and they experienced less stress.

The cost savings from supportive housing is likely to be much higher than reported here. A number of costs were infeasible to include or beyond the scope of this analysis, including the homeless system and related costs, substance use treatment costs, social costs, and many others. Also, cost savings likely continued in the years following this study time frame.

In sum, supportive housing reduced the volume of publicly-funded services residents used, changed the type of services used, and resulted in a significant cost savings over time.

Methodology

The purpose of this study was to investigate how permanent supportive housing impacts residents' reliance on primarily publicly-funded services. The key research questions are:

1. Does living in supportive housing change the **volume** of publicly-funded services residents use?
2. Does living in supportive housing change the **type** of publicly-funded services residents use?
3. Does living in supportive housing decrease the **cumulative cost** of services residents use?

The study was structured as a repeated measures panel design, using a 4-year time period for each resident. The data were divided into pre- and post-time periods, each time period being 2 years. The analysis compared the volume, type, and cost of services each resident used in the 2 years before supportive housing to the 2 years after they entered supportive housing.

Recruitment for the study ran from February to September 2006. To get a cross-section of the typical composition of Illinois supportive housing residents at a given time, all residents in the supportive housing projects at the time of recruitment were eligible for the study, regardless of how long they lived there or their reasons for living there. Researchers obtained consent and release of information forms to access data from state agencies, local hospitals, and jails. Data requests were sent to the entities in Table 1 for the time period of July 1, 1999 to June 30, 2006 for information on use of listed services:

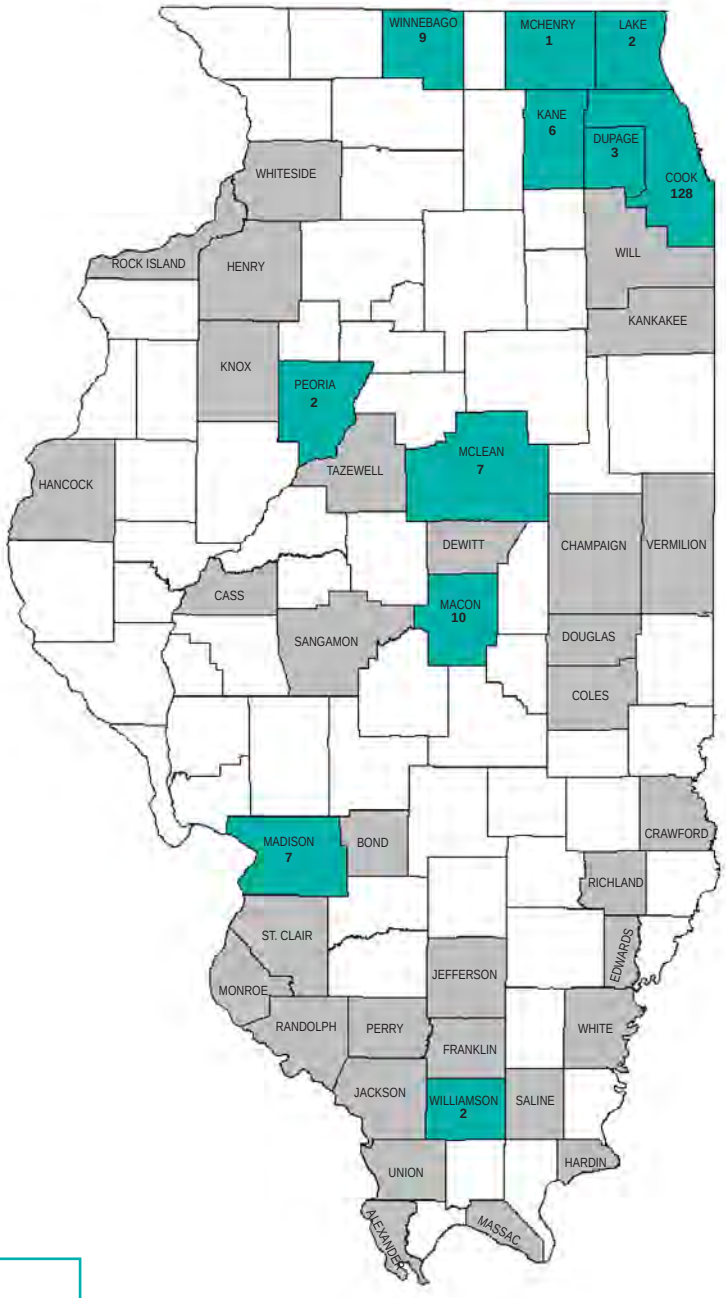
Table 1: Service-Type Categories for Each System

	Inpatient/Acute Services	Outpatient/Preventive Services	Incarceration
Medicaid-Funded Services (DHFS)	Inpatient medical care	Pharmacy	
		Home health & medical equipment	
	Inpatient psychiatric care	Outpatient medical care	
	Nursing homes	Outpatient psychiatric care	
	Ambulance	Physician care	
		Care by other providers	
		Dental care	
Uncompensated Hospital Services (Local Hospitals)	Inpatient medical care	Outpatient medical care	
	Inpatient psychiatric care	Outpatient psychiatric care	
	Emergency room	Outpatient care: Type unknown	
Substance Use Treatment Services (DASA)	Residential rehabilitation	Outpatient treatment	
	Halfway house		
	Recovery home	Case management	
	Detoxification	Toxicology	
State Mental Hospital (DMH)	Inpatient mental hospital		
State Prison (IDOC)			State prison
County Jails			County jails

Background on Study Participants

177 residents in the study had complete data for their 2 pre-supportive housing years and 2 post-supportive housing years. In order to look comprehensively at the effects of supportive housing over a 2-year time frame, this report focuses on this 177 sample, which had the following characteristics:

- They had been in supportive housing for an average of 38 months. Time in supportive housing ranged from 21 months to 63 months.
- They had an average age at time of the study enrollment of 43, ranging from 18 to 68 years of age.
- Over half (52%) were male and 48% were female.
- In terms of race/ethnicity, 69% were African American, 26% White, 4% Latino, and 0.6% other.
- Six percent identified themselves as veterans.
- In the week prior to entry into supportive housing, 39% lived in a homeless shelter or transitional housing, 15.8% were living doubled up with family or friends, almost 10% were unsheltered, and 9% were in some type of facility (nursing home, jail, treatment center, etc.).
- They were from 26 supportive housing projects in 11 counties in Illinois.



Counties with supportive housing projects

Counties with supportive housing projects participating in the study and number of residents enrolled in the study

Results: System-Specific Service Analysis

Medicaid-Reimbursed Service Use (Illinois Department of Health and Family Services)

Medicaid is a state-administered health insurance program that is available only to people with limited income who meet certain eligibility requirements.

Does living in supportive housing change the volume of Medicaid services residents use?

While there was a slight increase in the volume of Medicaid services used from pre- to post-supportive housing, there was a shift in type of services used from more expensive, intensive services to less expensive, preventive services.

- Medicaid-reimbursed **inpatient psychiatric care** users decreased almost 20% and use decreased over 66% from pre- to post-supportive housing.
- **Nursing home** use decreased 97%.
- As expected, use of health stabilizing services increased, such as **pharmacy**, **home health care,** and **dental care**.
- Although Medicaid-funded **inpatient medical care** and **outpatient psychiatric care** use increased post-supportive housing, the large increase was concentrated during the first 6 months after entry into supportive housing. After those 6 months of stabilization, the use of inpatient care reduced dramatically.
- While use of Medicaid-funded **outpatient medical care** increased 26% during the post-supportive housing time period, there was virtually no cost increase.

Does living in supportive housing change the type of Medicaid services residents use?

Yes. There was a shift from using Inpatient/Acute Medicaid services prior to entry into supportive housing to relying more on Outpatient/Preventive Medicaid services after living in supportive housing.

- The use of Inpatient/Acute Medicaid services decreased 82%, while the use of Outpatient/Preventive services increased 32%.

Does living in supportive housing decrease the cumulative cost of Medicaid services residents use?

Yes, there was a cost savings of over $183,000 from pre- to post-supportive housing.

- Before supportive housing, the sample of 177 residents used a total of $1,422,399 worth of Medicaid-reimbursed health services. After entry into supportive housing, the group used $1,240,128 worth of services.
- Overall, the cost of Inpatient/Acute services decreased 38% from pre- to post-supportive housing, while the cost of Outpatient/Preventive services increased only 12%.

Uncompensated Hospital Service Use (Local Hospitals)

Since not all residents had Medicaid health insurance coverage during the entire study period, residents were asked which local hospitals they used during the study period, and researchers collected records from those hospitals. There is a small chance that some in the sample had private insurance; however, due to the demographics of the sample and their lack of employment income, this is very unlikely. Reported here is the use of hospital services that were likely not reimbursed by Medicaid or other health insurance.

Does living in supportive housing change the volume of uncompensated hospital services residents use?

Yes.

- **Emergency room** total use decreased over 40%.
- Use of **inpatient medical care** went down 83%.
- **Outpatient medical care** and the **emergency room** were the most commonly used services pre-supportive housing. **Outpatient medical care** and **inpatient psychiatric care** were the most commonly used services post-supportive housing.
- **Outpatient medical care** and **outpatient psychiatric care** use remained almost the same from pre- to post-supportive housing.

Does living in supportive housing change the type of uncompensated hospital services residents use?

Yes, the number of uses of Inpatient/Acute uncompensated hospital services declined 17%; however, the number of uses of Outpatient/Preventative uncompensated hospital services remained the same.

Does living in supportive housing decrease the cumulative cost of uncompensated hospital services residents use?

Yes, there was a total cost savings of $27,968 from pre- to post-supportive housing.

- Before supportive housing, the sample of 177 residents used $133,429 worth of uncompensated hospital services. After entry into supportive housing, they used $105,461 worth of services.
- There was a 25% cost decrease from pre- to post-supportive housing in Inpatient/Acute services and a 9% cost decrease from pre- to post-supportive housing in Outpatient/Preventive services.

Results: System-Specific Service Analysis

State Mental Health Hospital Use (Illinois Department of Human Services, Division of Mental Health)

The Division of Mental Health in Illinois operates inpatient mental health hospitals that are not funded through Medicaid for adults and youth with mental disabilities. The goal of inpatient mental health hospitals is to help people through crises, stabilize them, and move them forward using outpatient services once they leave.

Does living in supportive housing change the volume of mental health hospitalizations residents use?

Yes, there was a significant decline in mental health hospitalizations.

- The number of users and uses of mental health hospitals decreased 90% from pre- to post-supportive housing.
- Overnight stays in mental health hospitals ranged from 1 to 415 during the pre-supportive housing time period. During the post-supportive housing time period, just one person stayed in a mental health hospital for 2 nights.
- The number of overnight stays in mental health hospitals went down almost 100%.

Does living in supportive housing change the type of mental health services residents use?

Yes.

- Mental health hospital care is considered an Inpatient/Acute service. There was a drastic reduction in this type of care.
- None of the 11 people who used state mental health hospitals in their pre-supportive housing time period used them in their post-supportive housing time period. Five of the 11 used Medicaid-reimbursed outpatient psychiatric care in their post-supportive housing time period.

Does living in supportive housing decrease the cumulative cost of mental health hospitalizations?

Yes, there was almost a $400,000 cost savings in mental health hospitalizations from pre- to post-supportive housing.

- The sample of 177 residents used $400,872 worth of state mental health hospital services before entry into supportive housing and only $873 after entry into supportive housing.

Substance Use Treatment Service Use (Illinois Department of Human Services, Division of Alcohol and Substance Abuse)

The Division of Alcoholism and Substance Abuse is responsible for coordinating all programs that deal with problems resulting from substance use. They focus on prevention, intervention, treatment, and rehabilitation for alcohol and other drug dependency.

Does living in supportive housing change the volume of substance use treatment services residents use?

While number of uses were not available for substance use treatment services, based on declines in users of all services except case management and toxicology, it can be assumed there was a decrease in the volume of substance use treatment services used.

Does living in supportive housing change the type of substance use treatment services residents use?

Yes.

- From pre- to post-supportive housing, users of Inpatient/Acute services decreased 60%, while the number of users of Outpatient/Preventive services increased 11%.

Does living in supportive housing decrease the cumulative cost of substance use treatment services residents use?

While cost data were not available for substance use treatment services, based on declines in the number of users of the most intensive services, it can be assumed that there was a significant cost decline.

- Expensive overnight services such as **halfway houses** and **recovery homes** decreased 100% from pre- to post-supportive housing.

Results: System-Specific Service Analysis

Criminal Justice System Interactions

State Prisons (Illinois Department of Corrections)

Does living in supportive housing change the amount of time spent in state prison?

Yes, there was a 100% decrease in time spent in state prison from pre- to post-supportive housing.

- Overnight stays in prison ranged from 2 to 328 during the pre-supportive housing period, dropping to zero during the post-supportive housing time period.

Does living in supportive housing decrease the cumulative cost of time spent in state prison?

Yes, there was a cost savings of over $215,000 from pre- to post-supportive housing.

- Before supportive housing, the time the sample of 177 residents spent in state prison cost $215,759. After entry into supportive housing, residents did not spend any time in prisons; therefore, there was a 100% cost savings.

County Jails

Does living in supportive housing change the amount of time spent in county jails?

Yes, there was a significant decrease in time spent in county jails from pre- to post-supportive housing.

- The number of overnight stays decreased 86% from pre- to post-supportive housing.
- The length of stay in county jails ranged from 0 to 200 overnight stays during the pre-supportive housing period and 4 to 23 overnight stays during the post-supportive housing period--a significant reduction.

Does living in supportive housing decrease the cumulative cost of time spent in county jails?

Yes, there was a cost savings of over $27,000 from pre- to post-supportive housing.

- Before supportive housing, the sample spent time in county jails costing $32,099. After entry into supportive housing, this sample spent time costing $4,618.

Table 2: Summary of Change in the Cost of Services Used from the 2 Years Before to the 2 Years After Entry into Supportive Housing

	Total Cost PRE-Supportive Housing	Total Cost POST-Supportive Housing	Dollar Change in Total Cost from Pre- to Post-Supportive Housing	Percent Change in Cost
Medicaid-Reimbursed Service Use (Pre: N=84, Post: N=102)				
Inpatient medical care	$224,547	$340,192	$115,645	52%
Inpatient psychiatric care	$230,119	$74,223	-$155,896	-68%
Nursing home	$236,576	$6,512	-$230,064	-97%
Ambulance	$3,531	$7,232	$3,701	105%
Pharmacy	$220,592	$258,776	$38,184	17%
Home health care and medical equipment	$35,253	$70,443	$35,190	100%
Outpatient medical care	$151,210	$151,401	$191	0%
Outpatient psychiatric care	$224,223	$257,050	$32,824	15%
Physician care	$85,477	$63,578	-$21,899	-26%
Care by other providers	$6,770	$4,003	-$2,767	-41%
Dental care	$4,009	$5,719	$1,620	40%
Total Medicaid-Reimbursed Services	**$1,422,299**	**$1,239,128**	**-$183,271**	**-13%**
Uncompensated Hospital Service Use (Pre: N=37, Post: N=47)				
Inpatient medical care	$68,097	$16,545	-$51,552	-76%
Inpatient psychiatric care	$24,245	$55,519	$31,274	129%
Emergency room	$11,217	$6,078	-$5,139	-46%
Outpatient medical care	$28,976	$26,460	-$2,516	-9%
Outpatient psychiatric care	$894	$859	-$34	-4%
Outpatient care: Unknown type	-	-	-	-
Total Uncompensated Hospital Services	**$133,429**	**$105,461**	**-$27,968**	**-21%**
Mental Health Hospital Use (Pre: N=10, Post: N=1)				
Inpatient mental health hospital care	$400,872	$873	-$399,999	-100%
State Prison Interactions (Pre: N=11, Post: N=0)				
State prison	$215,759	$0	-$215,759	-100%
County Jail Interactions (Pre: N=9, Post: N=4)				
County jail	$32,099	$4,618	-$27,481	-86%
Substance Use Treatment Service Use (Pre: N=48, Post: N=44) *No cost data were available for substance use treatment services through the Illinois Department of Human Services, Division of Alcohol and Substance Abuse*				

Change in the Type of Services Used Over Time

Within each of the six systems studied, researchers looked at three different categories:

1. Inpatient/Acute: Services in this category are primarily expensive, overnight, and for emergency situations.
2. Outpatient/Preventive: Services in this category are less expensive, stabilizing, maintenance, and preventive care.
3. Incarceration: This includes county jails and state prisons.

There was a dramatic shift in the type of services used across all six systems (see Table 3). The majority of services used shifted from Inpatient/Acute and Incarceration before supportive housing, to Outpatient/Preventive after entry into supportive housing.

- There was a 77% decrease in the number of nights spent in Incarceration and an 83% decrease in the number of uses of Inpatient/Acute services after entry into supportive housing.
- These decreases in use correspond with a large decrease in the total cost. The total cost of Incarceration decreased 98% and Inpatient/Acute services decreased 58% in total cost.
- While Outpatient/Preventive service use increased 32%, there was only a corresponding 11% total cost increase from pre- to post-supportive housing.

Table 3: Category Change Over Time

	Percent Change from Pre- to Post-Supportive Housing				
	Number of Users	Number of Uses	Average Uses per User	Total Cost	Average Cost per User
Inpatient/Acute (not including substance use)*	0%	-83%	-83%	-58% (-$692,030)	-58%
Outpatient/Preventive	13%	32%	17%	11% ($80,793)	-2%
Incarceration	-77%	-98%	-91%	-98% (-$243,240)	-92%

*Substance use treatment services are not included in this analysis due to missing data on use and total cost.

Cost Savings

In the 2 years prior to entry into supportive housing, the 177 residents used $2,204,557 worth of services. In the 2 years after entry into supportive housing, these 177 residents used a total of $1,350,081 worth of services. Post-supportive housing costs declined the longer residents lived in supportive housing (see Table 4). Thirty percent of the total cost was accrued in months 1 through 6, declining to 21% in months 19 through 24 of the 2-year post-time period. This illustrates that fewer costs were accrued by residents as time in supportive housing increased and that cost reduction may likely continue beyond this study's time frame, resulting in even greater cost savings for long-term supportive housing residents.

Table 4: Post-Supportive Housing Cost Accrual in 6 Month Increments

Months After Entry into Supportive Housing	Percent of Total Post-Supportive Housing Costs Accrued
1-6 Months	30%
7-12 Months	27%
13-18 Months	22%
19-24 Months	21%

For these 177 residents, there was a 39% reduction in total cost with an overall cost savings of $854,477. This is an average cost savings of $4,828 per person from pre- to post-supportive housing for the 2-year time period across all of the systems included in this study minus substance use treatment services. This averages to $2,414 per person, per year.

Ten people in the sample can be considered high-cost users. High-cost users are those who used $50,000 or more worth of services during the 2 years before entering supportive housing. Their total cost of services in the 2 years before supportive housing ranged from $54,000 to $194,000 with a median cost of $107,000. Each of these 10 high cost users had a dramatic cost decrease from pre- to post-supportive housing. The average cost savings was $73,000 per person, with a cost savings range of $2,400 to $180,000.

The biggest cost savings came from three systems: state mental health hospitals, state prisons, and Medicaid. The sample of 177 residents saved close to $400,000 from a decrease in state mental health hospitalizations, over $215,000 from a decrease in state prison admissions, and $183,000 from a decrease in use of Medicaid-reimbursed services.

This cost savings is a conservative estimate due to substance use treatment services and some uncompensated outpatient hospital service costs not being included in this analysis. In addition, shelter costs, police costs, soup kitchens, community health clinics, and many other services related to homelessness were not captured; therefore, the overall cost savings after entry into supportive housing is likely much greater.

Discussion

This is the first statewide study that looks at the effects of permanent supportive housing on residents in Illinois and adds to the current research about the cost-effectiveness of supportive housing as a key component for eliminating homelessness. Supportive housing in Illinois not only reduced the homelessness and housing instability previously experienced by residents but also produced a large cost savings in a number of public systems. Based on resident interviews, many people also experienced enhanced quality of life, not solely as result of being stably housed, but also due to their increased use of preventive and maintenance services, particularly in health, mental health, and substance use service systems.

Implications for Practice and Policy

Supportive housing providers should give consideration to the following as they seek to enhance their services:

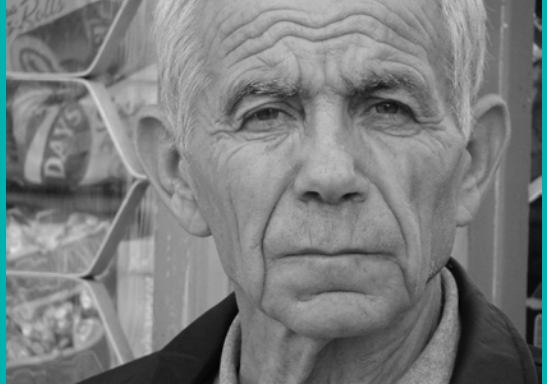
- In the first 6 months of permanent supportive housing residents need support in order to stabilize their health. Some services, such as inpatient medical care, saw a spike in use in the first 6 months of supportive housing which quickly decreased thereafter. In line with findings from other supportive housing studies, use of health services increased after people were housed, likely due to increased contact with case managers who made referrals to health professionals. While homeless, many people did not have access to such systems and deferred needed care. Health and mental health needs are an important initial assessment and referral piece for case managers to consider.
- Medicaid-reimbursed services and substance use services were the most frequently used both pre- and post-supportive housing. Case managers have an opportunity to educate about and refer residents to Outpatient/Preventive services, which not only saves money, but can help residents maintain stability in their health and lives.
- Supportive housing is effective with the most expensive users of public services, such as those with a mental illness or substance users. While these groups used high-cost services before entry into supportive housing, they benefited from being housed and produced a dramatic cost savings after entering supportive housing.
- There are implications of this analysis for targeting supportive housing. Supportive housing has a tremendous cost savings impact for people who might be considered the hardest to house: those with a mental illness, those who were formerly incarcerated, those with a disability or health issue, and those with histories of drug use. As projects seek to target populations in need, tailoring outreach and services for those with the aforementioned characteristics will result in cost savings as well as appropriate housing in the least restrictive setting.

Policymakers have an opportunity to prioritize people who are homeless and have barriers by housing them in supportive housing instead of in expensive, more restrictive settings:

- People are often inappropriately housed in nursing homes due to a lack of available supportive housing options. In addition, many patients need more intensive nursing care after a medical crisis, and since nursing homes do not want to discharge people back to homelessness, they retain them longer than necessary. Nursing homes are a very expensive housing option that should be relied on only for people who need full-time care, and supportive housing should be available for those who need less intensive supports and services to remain healthy and housed.
- People with mental illness are often unnecessarily placed in Institutes for Mental Disease, which are nursing homes with over 16 beds in which the majority of residents have a mental illness. For nursing homes with this designation, the federal government will not provide Medicaid reimbursement for services provided to people age 22 to 64. The state of Illinois ends up paying an average of $160 million annually to house people in these Institutes for Mental Disease. Many of these people could live on their own in supportive housing and save the state millions of dollars a year.

Policymakers have an opportunity to invest funds more wisely in Illinois by making permanent supportive housing available to more people in need:

- Time spent in jails and prisons plummeted for the supportive housing residents in this study, saving tens of thousands of dollars. Supportive housing is a better investment for the person who is homeless, for the community through reduced crime, and for the state in reduced correctional outlays.
- Once in supportive housing, residents can begin to stabilize their lives. They start receiving medical treatment, stabilize their medication, and are less likely to use expensive Inpatient/Acute services such as mental health hospitals and nursing homes.
- It is challenging to document cost savings from supportive housing and to fund services for supportive housing because government funding streams for different populations are compartmentalized. Funding for supportive housing services is needed from multiple state agencies, and there needs to be a mechanism for this to happen smoothly. For example, money seen from cost savings in prisons and nursing homes after entry into supportive housing needs to be able to easily shift to invest in supportive housing.



Residents' Perspectives

During in-depth interviews and a roundtable discussion with supportive housing residents, many indicated a variety of ways their lives had improved after entering supportive housing.

Residents reported that they:

- Learned how to pay bills
- Were able to be reunited with children and family
- Were able to save, especially for a car
- Experienced health improvements
- Were able to abstain from substance use
- Did not feel pressure to do things that they used to do, such as illegal activities
- Felt they had compassion, and they could give back to others
- Believed in themselves
- Had more confidence in themselves
- Felt great overall
- Felt like a human being again
- Were proud
- Were able to be around positive people and create a more positive outlook for themselves
- Reduced stress in their lives

Conclusion

This is the first statewide study that looks at the effects of supportive housing for residents in Illinois and adds to the current research about the cost-effectiveness of supportive housing as a key component for eliminating homelessness.

Overall, there was a cost savings in every system studied from pre- to post-supportive housing. There was a 39% reduction in total services cost from pre- to post-supportive housing with an overall cost savings of $854,477 for the 177 residents. This was an average cost savings of $4,828 per resident from pre- to post-supportive housing for the 2-year time period or $2,414 per resident, per year.

The true cost savings realized by supportive housing is likely to be much higher than reported here. There were a number of costs that were infeasible to include or beyond the scope of this analysis, including costs incurred by the homeless system and related services, substance use treatment costs, social costs, and many others.

Importantly, residents also shifted the type of services they used—from a high reliance on expensive Inpatient/Acute services (such as inpatient care, emergency rooms, and mental health hospitals) before they entered supportive housing to less expensive Outpatient/Preventive services (such as outpatient care, home health care, and case management) after they entered supportive housing. The volume of services used decreased for expensive Inpatient/Acute services and Incarceration and increased slightly for less expensive Outpatient/Preventive services.

This study underscores the importance of prioritizing more appropriate housing options for people living in restrictive settings who could live in the community if supportive housing were available. Supportive housing can not only reduce costs of public systems particularly in the areas of nursing homes, mental health, and criminal justice, but can also dramatically improve the quality of life for thousands of Illinoisans.

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The Heartland Alliance Mid-America Institute on Poverty

The Heartland Alliance Mid-America Institute on Poverty (MAIP) provides dynamic research and analysis on today's most pressing social issues and solutions to inform and equip those working toward a just global society. As such, MAIP:

- Conducts research to increase the depth of understanding and profile of social issues and solutions;
- Develops recommendations and action steps;
- Communicates findings using media, briefings, and web strategies to influence a broad base of decision makers; and
- Impacts social policy and program decisions to improve the quality of life for poor and low-income individuals.

For more information: 773.336.6075 | research@heartlandalliance.org | www.heartlandalliance.org/research

Supportive Housing Providers Association

The Supportive Housing Providers Association (SHPA) is a statewide association of organizations who provide supportive housing. SHPA enables increased development of supportive housing and supports organizations that develop and operate permanent supportive housing. The Supportive Housing Providers Association:

- Connects its member organizations, both staff and residents, with each other, with best practices, and with state/national policymakers and funders;
- Educates stakeholders regarding the efficacy and cost effectiveness of supportive housing; and
- Advocates for increased and integrated resources for supportive housing.

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Corporation for Supportive Housing (provided technical assistance for the study)

Established in 1992, the Corporation for Supportive Housing Illinois office works to promote the development of supportive housing to end long-term homelessness through three core products and services:

- Capacity building to enhance the supportive housing industry's skills and knowledge, so that the field has a greater ability to deliver high-quality housing and services over the long term;
- Financial and technical assistance to partners to expand the supply, availability, and variety of supportive housing;
- Promoting policy reforms and coordinated systems that make supportive housing easier to develop and operate.

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Mental Health America of Illinois

Persons with Mental Illnesses in Nursing Homes

Testimony Prepared for Joint Senate Committe Hearing on Nursing Home Safety
November 5, 2009

Illinois has long struggled with problems relating to the placement of persons with mental illnesses in nursing homes. Unfortunately, despite periodic attention from the media and from various government agencies, we have not yet created a thoughtful and systematic response to these problems. There are serious systemic problems with our excessive reliance on nursing homes as placements for persons with mental illnesses, with the way many nursing homes treat persons with mental illnesses and with the government regulation of the treatment of persons with mental illnesses in nursing homes.

In addressing these serious problems, it is important to remember:

- Like any other type of facility, there are nursing homes that are better and those that are worse.
- Most person with mental illnesses are not dangerous and are not criminals.
- Most of the over 260,000 persons in Illinois diagnosed with two of the most serious mental illnesses–schizophrenia and bipolar disorder–are not living in any type of institution; nor do they belong in one.
- Most criminals are not mentally ill.
- Persons who need to reside in a nursing home due to the infirmities associated with old age or physical disability are not immune from mental illnesses. Thus, no matter what policy choices Illinois makes about the placement of persons who are in nursing homes ***only*** because they have a serious mental illness, it will be important to insure that elderly and physically disabled persons are provide with adequate and humane mental health services when needed.

<u>Specific serious problems involving the placement of persons with mental illnesses in nursing homes include:</u>

- Inadequate intake screening and assessment
- Insufficient staff
- Staff lacks training/expertise regarding the diagnosis/assessment and treatment of persons with mental illnesses

- Inadequate understanding of and monitoring of use of psychotropic medications
- Government oversight of the quality and quantity of mental health services provided in nursing homes has been inadequate.
- Absence of a recovery focus and discharge planning
- Failure of nursing homes classified as "Institutes for Mental Diseases" (IMD) and specialized mental health units within other nursing homes to comply with the Mental Health and Developmental Disabilities Code as required by *Muellner v. Blessing Hospital*, 335 Ill. App. 3d 1079; 782 N.E.2d 799; 270 Ill. Dec. 240 (2002)
- Unnecessary placement of persons with mental illnesses in nursing homes, particularly in IMD nursing homes.

Recommendatons:

1. The Governor should settle the *Williams v. Blagojevich* litigation which seeks to insure that only those persons who need institutional care are placed in nursing homes.
2. The Illinois Department of Public Health should enforce the *Muellner* decision by enacting and enforcing specific new regulations.
3. The Illinois Department of Public Health should hire more staff with mental health expertise to oversee nursing homes.
4. The nine inpatient psychiatric facilities operated by the Department of Human Services, Division of Mental Health should refrain from discharging persons to nursing homes unless the need for such a placement is based upon a condition other than a mental illness.
5. Remove all persons from nursing homes who are there *solely* due to a mental illness.
6. Use the money saved from reducing the number of person with mental illnesses in nursing homes to fund supportive housing, Assertive Community Treatment, peer support services, supported employment and other recovery-oriented services.
7. Adopt the attached legislation

Mark J. Heyrman and Rita Velez Carreras
Public Policy Committee
Writers' direct line: 773-753-4440

Proposals Regarding Persons with Mental Illnesses in Nursing Homes

1. Prohibit the placement of persons with mental illnesses in nursing homes unless their need for placement is based upon a condition other than their mental illness.

210 ILCS 45/2 201.5. Screening prior to admission.
(a) All persons age 18 or older seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. In addition, any person who seeks to become eligible for medical assistance from the Medical Assistance Program under the Illinois Public Aid Code to pay for long term care services while residing in a facility must be screened prior to receiving those benefits. Screening for nursing facility services shall be administered through procedures established by administrative rule. Screening may be done by agencies other than the Department as established by administrative rule. This Section applies on and after July 1, 1996.
(b) In addition to the screening required by subsection (a), a facility, except for those licensed as long term care for under age 22 facilities, shall, within 24 hours after admission, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons age 18 or older seeking admission to the facility. Background checks conducted pursuant to this Section shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. If the results of the background check are inconclusive, the facility shall initiate a fingerprint based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk which may be established by Departmental rule. A waiver issued pursuant to this Section shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. The facility shall provide for or arrange for any required fingerprint based checks to be taken on the premises of the facility. If a fingerprint based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident.
A facility, except for those licensed as long term care for under age 22 facilities, shall, within 60 days after the effective date of this amendatory Act of the 94th General Assembly, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons who are residents of the facility on the effective date of this amendatory Act of the 94th General Assembly. The facility shall review the results of the criminal history background checks immediately upon receipt thereof. If the results of the background check are inconclusive, the facility shall initiate a fingerprint based check unless the fingerprint based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of

potential risk which may be established by Departmental rule. A waiver issued pursuant to this Section shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. The facility shall provide for or arrange for any required fingerprint based checks to be taken on the premises of the facility. If a fingerprint based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident.
(c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1 114.01, the facility shall immediately fax the resident's name and criminal history information to the Illinois Department of Public Health, which shall conduct a Criminal History Analysis pursuant to Section 2 201.6. The Criminal History Analysis shall be conducted independently of the Illinois Department of Public Health's Office of Healthcare Regulation. The Office of Healthcare Regulation shall have no involvement with the process of reviewing or analyzing the criminal history of identified offenders.
(d) The Illinois Department of Public Health shall keep a continuing record of all residents determined to be identified offenders under Section 1 114.01 and shall report the number of identified offender residents annually to the General Assembly.
(e) No person may be admitted to any long-term care facility as defined in this Act when such placement if for the sole purpose of providing mental health services as defined in the Mental Health and Developmental Disabilities Code.

2. Amend the MHDDCode to prohibit DHS from discharging persons from state- operated hospitals to IMDs

405 ILCS 5/3-902. Director initiated discharge.
(a) The facility director may at any time discharge an informal, voluntary, or minor recipient who is clinically suitable for discharge.
(b) The facility director shall discharge a recipient admitted upon court order under this Chapter or any prior statute where he is no longer subject to involuntary admission. If the facility director believes that continuing treatment is advisable for such recipient, he shall inform the recipient of his right to remain as an informal or voluntary recipient.
(c) When a facility director discharges or changes the status of a recipient pursuant to this Section he shall promptly notify the clerk of the court which entered the original order of the discharge or change in status. Upon receipt of such notice, the clerk of the court shall note the action taken in the court record. If the person being discharged is a person under legal disability, the facility director shall also submit a certificate regarding his legal status without disability pursuant to Section 3 907.
(d) When the facility director determines that discharge is appropriate for a recipient pursuant to this Section or Section 3 403 he or she shall notify the state's attorney of the county in which the recipient resided immediately prior to his admission to a mental health facility and the state's attorney of the county where the last petition for

commitment was filed at least 48 hours prior to the discharge when either state's attorney has requested in writing such notification on that individual recipient or when the facility director regards a recipient as a continuing threat to the peace and safety of the community. Upon receipt of such notice, the state's attorney may take any court action or notify such peace officers that he deems appropriate.
(e) The facility director may grant a temporary release to a recipient whose condition is not considered appropriate for discharge where such release is considered to be clinically appropriate, provided that the release does not endanger the public safety.
(f) No person may be discharged from a Department mental health facility to any long-term care facility classified as an Institute for Mental Diseases under Federal Medicaid law. Nothing in this Section shall be deemed to prevent the transfer of any person from one Department mental health facility to another Department mental health facility

3. Amend the Mental Health Administrative Code to prohibit DHS from discharging persons from state-operated hospitals to IMDs

20 ILCS 1705/15

Before any person is released from a facility operated by the State pursuant to an absolute discharge or a conditional discharge from hospitalization under this Act, the facility director of the facility in which such person is hospitalized shall determine that such person is not currently in need of hospitalization and:
(a) is able to live independently in the community; or
(b) requires further oversight and supervisory care for which arrangements have been made with responsible relatives or supervised residential program approved by the Department; or
(c) requires further personal care or general oversight as defined by the Nursing Home Care Act, for which placement arrangements have been made with a suitable family home or other licensed facility approved by the Department under this Section; or
(d) requires community mental health services for which arrangements have been made with a community mental health provider in accordance with criteria, standards, and procedures promulgated by rule.
No person released from a facility operated by the State pursuant to an absolute discharge or conditional discharge from hospitalization under this Act shall be placed in any long-term care facility classified as an Institute for Mental Diseases under Federal Medicaid law.

4. Codify (or expand) the Illinois Appellate Court decision in *Muellner v. Blessing Hospital*, 335 Ill. App. 3d 1079; 782 N.E.2d 799; 270 Ill. Dec. 240 (2002) (applies the MHDDCode to nursing homes for people with mental illnesses).

405 ILCS 5/1 114
"Mental health facility" means any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, long-term care facilities as defined in the Nursing Home Care Act, evaluation facilities, and mental health centers which provide treatment for such persons.

405 ILCS 5/1-123 (Alternative One)
"Recipient of services" or "recipient" means a person who has received or is receiving treatment or habilitation. Recipient includes any person receiving mental health services in a long-term care facility as defined in the Nursing Home Care Act.

or

405 ILCS 5/1-123 (Alternative Two)
"Recipient of services" or "recipient" means a person who has received or is receiving treatment or habilitation. Recipient includes anyone residing in a long-term care facility as defined in the Nursing Home Care Act provided that the primary reason for the placement of the recipient in the facility is for the treatment of her or his mental illness.

405 ILCS 5/3-200
(a) A person may be admitted as an inpatient to a mental health facility, including any long-term care facilities as defined in the Nursing Home Care Act, for treatment of mental illness only as provided in this Chapter, except that a person may be transferred by the Department of Corrections pursuant to the Unified Code of Corrections. A person transferred by the Department of Corrections in this manner may be released only as provided in the Unified Code of Corrections.
(b) No person who is diagnosed as mentally retarded or a person with a developmental disability may be admitted or transferred to a Department mental health facility or, any portion thereof, except as provided in this Chapter. However, the evaluation and placement of such persons shall be governed by Article II of Chapter 4 of this Code.

405 ILCS 5/6-108 (New)
In the event of any conflict between the provisions of this Act and the Nursing Home Care Act, the provisions of the Nursing Home Care Act shall govern.

MUELLNER v. BLESSING HOSPITAL

335 Ill. App. 3d 1079; *782 N.E.2d 799; 270 Ill. Dec. 240* (2002)

Appeal from Circuit Court of Adams County No. 01P228 Honorable Thomas J. Ortbal, Judge Presiding.

PRESIDING JUSTICE MYERSCOUGH delivered the opinion of the court:

In January 2002, the trial court found respondent, Sandra Muellner, to be a disabled adult and appointed petitioner, the Office of State Guardian (State Guardian), as limited guardian of her person. Respondent appeals, arguing the trial court erred in authorizing the State Guardian to place her in a nursing home's behavioral unit without proceeding for her involuntary commitment under chapter III of the Mental Health and Developmental Disabilities Code (*405 ILCS 5/3-100* through 3-1003).

I. BACKGROUND

In September 2001, respondent was 55 years old and resided in Hotel Quincy Apartments. The manager noticed respondent holding a towel in her arms and acting like she had a baby. A maid convinced respondent to go to Blessing Hospital (Blessing), where she was voluntarily admitted as an inpatient to an adult psychiatric unit. In October 2001, Melissa Penn, a social worker at Blessing, filed a guardianship petition and a petition for temporary guardianship. Penn alleged respondent was a disabled person because she was unable to care for herself and she suffered from chronic paranoid schizophrenia with delusions. The petitions sought to appoint the State Guardian as guardian of respondent's person with authority to make residential placement. The trial court appointed the State Guardian as respondent's temporary guardian for up to 60 days. The trial court authorized the State Guardian to make residential placement.

In November 2001, the State Guardian, as respondent's temporary guardian, placed respondent with New Horizons in Sycamore Health Care (Sycamore), a 24-hour skilled nursing facility. New Horizons is a behavioral unit that works to stabilize psychiatric patients. It has an in-house psychiatrist and offers group therapy classes. The facility is not locked, but access to other areas of Sycamore or the outside community is restricted until the resident gains levels of trust.

In January 2002, the trial court held a hearing on Penn's guardianship petition. Dr. Lee Johnson, a psychiatrist, treated respondent for schizophrenia. Dr. Johnson noted that respondent rarely took prescribed medication. Julie Irvine of the West Central Illinois Center for Independent Living testified for respondent. Irvine stated respondent was capable of living independently in the community with visits by personal assistants to her home. Respondent filed a motion to limit the proposed guardian's power to place her in a nursing home. After taking the matter under advisement, the trial court denied respondent's motion as moot and appointed the State Guardian as limited guardian of respondent's person. The trial court granted the State Guardian authority to place respondent in a group home, shelter-care facility, or in the community. The trial court conditioned the State Guardian's authority to residentially place respondent in a skilled-care nursing facility; the State Guardian had to determine that respondent's placement in a less

restrictive environment would cause substantial harm to her.

II. ANALYSIS

Respondent argues the trial court erred in authorizing the State Guardian to place her in a nursing home's behavioral unit without proceeding for her involuntary commitment under chapter III of the Mental Health Code (*405 ILCS 5/3-100* through 3-1003).

* * *

Nursing Home as a Mental Health Facility

Section 11a-3(a) of the Probate Act of 1975 (Probate Act) (*755 ILCS 5/11a-3(a)*) authorizes a trial court to appoint a guardian for a disabled person. A guardian of the person has custody of the ward. *755 ILCS 5/11a-17(a)*. The guardianship order may specify the conditions on which the guardian may admit the ward to a residential facility without further court order. *755 ILCS 5/11a-14.1* . However, a trial court may not grant a guardian the power to admit a nonconsenting ward to a mental health facility for treatment as a voluntary patient. *In re Gardner, 121 Ill. App. 3d 7, 12, 459 N.E.2d 17, 20, 76 Ill. Dec. 608 (1984)*. Section 3-200(a) of the Mental Health Code (*405 ILCS 5/3-200(a)*) provides that "[a] person may be admitted as an inpatient to a mental health facility for treatment of mental illness only as provided in" chapter III of the Mental Health Code.

In the present case, the trial court authorized the State Guardian to admit respondent to a skilled-care nursing facility, and the State Guardian placed respondent in New Horizons, which is a behavioral unit of a skilled-care nursing facility. Although the State Guardian has confessed error, this court is not bound by a confession of error. *People v. Lavallier, 298 Ill. App. 3d 648, 649, 698 N.E.2d 704, 705, 232 Ill. Dec. 613 (1998)*. Therefore, we decide whether a nursing home's behavioral unit qualifies as a "mental health facility" under the Mental Health Code.

Section 1-114 of the Mental Health Code (*405 ILCS 5/1-114*) defines "mental health facility" as:

> any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons.

Section 1-113 of the Mental Health Code (*405 ILCS 5/1-113*) defines "licensed private hospital" as:

> any privately owned home, hospital, or institution, or any section thereof which is licensed by the Department of Public Health and which provides treatment for persons with mental illness.

The State Guardian claims that the definition of "mental health facility" is limited to those facilities with a "primary purpose" of treating mental illness. Amicus curiae suggests that any

nursing home may become a "mental health facility" if a single mentally ill person is admitted for mental health treatment. We reject these interpretations because they depart from the plain language of section 1-114. See *People v. Ellis, 199 Ill. 2d 28, 39, 765 N.E.2d 991, 997, 262 Ill. Dec. 383 (2002).*

Instead, we determine that New Horizons qualifies under the "licensed private hospital" portion of the definition of a "mental health facility" in section 1-114 of the Mental Health Code. As this court noted in *In re Moore, 301 Ill. App. 3d 759, 766, 704 N.E.2d 442, 446, 235 Ill. Dec. 93 (1998),* sections 1-113 and 1-114 of the Mental Health Code recognize that a facility may have sections for the treatment of mentally ill persons. The record shows that Sycamore is licensed by the Illinois Department of Public Health and New Horizons, a section of Sycamore, provides treatment for persons with mental illness.

Therefore, the trial court erred in permitting the State Guardian to place respondent in a mental health facility without requiring the State Guardian to proceed under the Mental Health Code.

III. CONCLUSION

For the reasons stated, we reverse the portion of the trial court's limited guardianship order that authorizes the State Guardian to place respondent in a skilled-care nursing facility to the extent it allows the State Guardian to admit respondent to a mental health facility without complying with the Mental Health Code. We affirm the trial court in all other respects and direct the trial court on remand to enter an order restricting the State Guardian's authority to admit respondent to a mental health facility without complying with the Mental Health Code.

KNECHT and APPLETON, JJ., concur.

Inappropriate Nursing Home Placements

Testimony of AFSCME Council 31
Before a Joint Hearing of the
Senate Human Service and Public Health Committees

My name is Anne Irving and I am the Director of Public Policy for AFSCME Council 31. I am also a member of the Illinois Mental Health Planning and Advisory Council.

AFSCME's view of this problem is informed by our members, who see the issue from several perspectives.

- The parole agents we represent see mentally ill felons ending up in nursing homes because there are not sufficient alternatives for housing and support.
- AFSCME members in the Illinois Department of Public Health's Bureau of Long Term Care who are part of the teams that inspect nursing homes are hard pressed to perform regular licensure and investigative surveys given the large number of homes in Illinois and their limited staff.
- In state prisons our members see inmates with untreated or undertreated mental illness being released unprepared to function in the community.
- And in our state's remaining public mental health hospitals, AFSCME members are increasingly under pressure to reduce the lengths of stay for the seriously mentally ill individuals they treat.

This committee wants to focus on solutions. Here are some:

- IDPH's long term care bureau has never been adequately staffed to effectively regulate and monitor the 1,200 long term care facilities in our state. IDPH has a staff of about 200 surveyors, who function as teams of three or four surveyors with different areas of expertise. They must conduct annual surveys that can last several days, and conduct follow up inspections at the same facility if problems are found. In addition the same surveyors must respond to some 19,000

complaints called into the IDPH Nursing Home Hotline each year. If we are serious about regulating these homes, we need to increase staffing in the Bureau of Long Term Care.

- The drastic downsizing of state psychiatric hospitals—without the development of appropriate alternative treatment settings--has led to the criminalization of individuals with mental illness. County jails and state prisons have become the new mental health hospitals. Yet treatment within the confines of correctional systems is sorely lacking. Mental health treatment urgently in the Department of Corrections urgently needs to be improved. Mental illness left untreated in prison means we as a state have missed an opportunity to turn someone's life around. Better identification of and treatment for mentally ill inmates while in prison will result in inmates better equipped for their release back into the community. And there must be alternatives for seriously mentally ill inmates when they are released from prison that provide housing and support.

- Finally, we should avoid repeating the mistakes of the past. The Tribune series of articles about seriously mentally ill felons in nursing homes made the point that this problem – the criminalization of mental illness and the lack of clinically directed long term support for those with chronic mental illness – was an unintended consequence of deinstitutionalization.

  Yet right now the Department of Human Services is once again attempting to parcel out the service area of Tinley Park Mental Health Center to private hospitals. Community hospitals in the Southland, as well as consumers and other stakeholders in the Tinley Park catchment area – already rejected this privatization plan 5 years ago. The Task Force that DHS formed then called for a new public hospital to serve the region. The Department never moved forward with that plan, and now DHS is back with the same old plan.

  We must respect the role state hospitals play as part of the system of care for the most seriously mentally ill. Patients are often referred after maxing out their health insurance in private hospitals. They may need a longer length of stay to find the right medication to recover. The role of the public hospital in the system should be acknowledged,

and any plan to privatize these services as is happening again at Tinley Park should be rejected.